

**A STUDY OF THE
ECONOMIC IMPACT OF
HIV/AIDS ON
SELECTED BUSINESS
ORGANIZATIONS IN
GHANA**

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1.0 HIV/AIDS IN GHANA

1.1 Introduction

Since the Mid 1980s, HIV has spread to almost every country in the world. One of the most devastating aspects of HIV is that it tends to kill young people who are at the heart of both economic and social activity – workers, managers, technicians, parents, etc.

This disease and its consequences present a major obstacle and challenge to economic growth and stability of the workforce of both the public and private sectors.

It has been acknowledged globally that HIV/AIDS can have an important impact on the economic development of both the public and private sectors. The disease and its consequences present a major obstacle and challenge to economic growth and stability of a workforce. In many countries, it is recognized that HIV/AIDS now threatens profits, productivity and human welfare advances achieved over several decades. Thus, both private and public sector organizations have strong economic and social reasons for vigorously promoting HIV/AIDS prevention and care activities.

The number of studies in African countries have shown that the economic impact of HIV/AIDS is significant. The impact of HIV/AIDS is experienced by many sectors, including households, health care, education, agriculture and business. The impact of the disease for the business sector is reflected in both increased expenditures and decreased revenues. Many industries in Sub-Saharan African countries are facing increased levels of absenteeism and are having to recruit replacement labour as their staff fall sick and die. This results in high expenditures from increases in recruitment and training costs, health care medical insurance, sickness and burial payments. Revenues may decrease because of absenteeism due to illness or attendance at funerals and time spent on training. In a recent survey of businesses in thirty African countries, the two main impacts of HIV/AIDS on both workforce and daily operations were “time lost to AIDS – related sickness” followed by “Health care costs”.

In Ghana there is a dearth of studies on the economic impact of HIV/AIDS. In recognition of the possible consequences of HIV/AIDS on business concerns, a desk review of existing data was carried out. In addition, a number of senior managers were interviewed to ascertain the measures that have been put in place in various institutions to prevent and control HIV infections among their staff and to minimize the economic impact of the disease on the business. The purpose of this initial review was twofold:

- i. to determine what additional information is needed to facilitate the development of an advocacy tool for the sensitization of management at the workplace; and
- ii. to encourage various business institutions to assess in realistic manner what HIV means to them and to develop an appropriate response.

This study is therefore an attempt to determine some of these parameters to better inform business since the private sector in particular has been targeted as the engine of growth for government.

1.2 The Structure and Trend of the Ghanaian Economy

Ghana's economy has since independence in March 1957 been a mixed one. Just after independence, Ghana opted for an economy that depended mainly on state controlled institutions with little attention paid to the private sector. In recent times, however, the private sector, having been identified and acknowledged as the engine of growth of the Ghanaian economy, is being supported to fulfill its role. The economy, therefore, includes a small capital-intensive modern sector, involving mining, a few manufacturing establishments with small-scale business enterprises and a largely traditional agricultural sector. With time, the country has moved from a largely state-controlled economy to a market-oriented one in which private initiative and entrepreneurship are acknowledged as the main driving forces for Ghana's socio-economic development.

Agriculture has been the largest source of employment in Ghana although the Services sector has been expanding in recent years with a decline in Industry. The records indicate that in 1992, the proportion of the population employed in agriculture was 62.2% as against 10.0% and 27.8% respectively in Industry and Services. By 1997, however, the report showed that Agriculture and Industry had declined to 55.9% and 7.2% respectively with services increasing to 38.0% (GSS, 1997).

The contribution of each of the three sectors to Ghana's Gross Domestic Product (GDP), on the other hand, suggests a higher contribution by Industry relative to the proportion of the population it offers employment to. As is presented in Table 1, the percentage contribution to GDP by each sector of Ghana's economy over the years shows that Agriculture has consistently contributed around 40% of GDP with the remaining 60% shared between Industry and the Services sectors although the Services sector's contribution appears slightly higher than that of Industry.

Table 1. Percentage Contribution to GDP by Sector, 1993-1998 at Constant 1993 Prices

Year	Sector		
	Agriculture	Services	Industry
1993	41.4	30.8	29.8
1994	40.8	31.3	27.9
1995	40.6	31.5	27.9
1996	40.8	31.3	27.9
1997	40.4	31.6	28.0
1998	40.5	32.1	27.4

Source: Ghana Statistical Service, Accra, cited in ISSER, "The State of the Ghanaian Economy in 1998", 1999, p.94

With such considerable contribution to GDP by Industry relative to the small proportion of the population it employs, it is important that the impact of HIV/AIDS to Industry be taken seriously. This is particularly so considering that HIV/AIDS, to date, has attacked the most economically active population wherever it strikes. This is, however, not to state that HIV/AIDS affects only Industry but Agriculture and Services as well. What is at stake then is the extent to which we can expand the manufacturing and industrial sector in particular by evolving programmes to stem the HIV/AIDS tide as we strive to attain a middle-income economic status in the foreseeable future.

1.3 Status of the HIV/AIDS Epidemic In Ghana

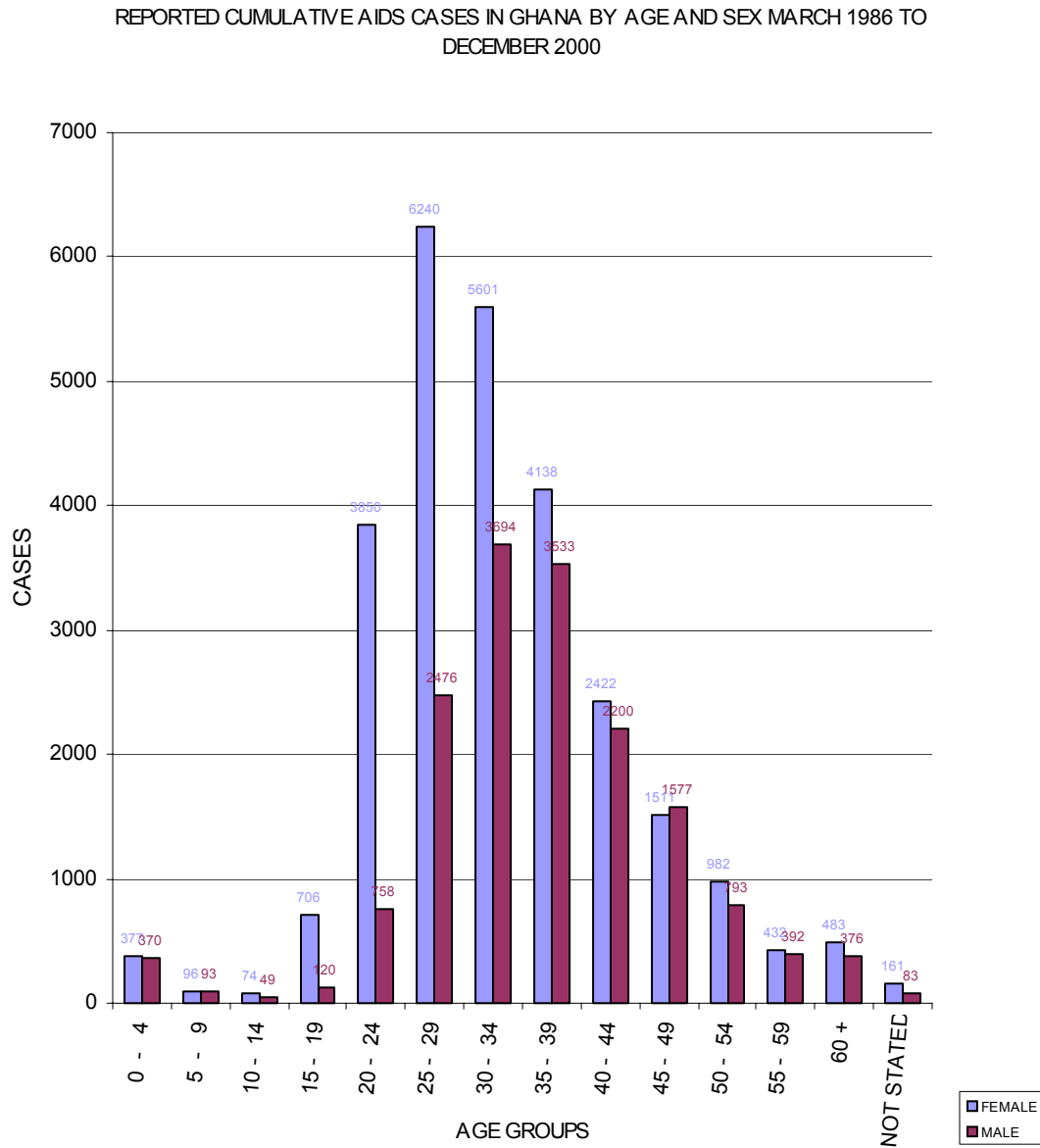
The first cases of AIDS were reported in Ghana in March 1986. By the end of that year a total of 42 cases had been reported to the health authorities. The number of reported cases has been increasing steadily over the years with a cumulative total of 43,587 as at the end of December 2000. This means that in the year 2000 alone 6,289 cases were added to the 1999 figure. This may in part be due to improvements in the case reporting of AIDS cases countrywide. The increase may also be as a result of increasing spread of infection. The estimated level of reporting is 30%

**TABLE 2: Reported cumulative AIDS cases in Ghana by age and sex
1986 - 2000**

AGE GROUP (YEARS)	FEMALE		MALE		TOTAL	
	NO.	%	NO.	%	NO.	%
0 – 4	377	1.4	370	2.2	747	1.7
5 – 9	96	0.4	93	0.6	189	0.4
10 – 14	74	0.3	49	0.3	123	0.3
15 – 19	706	2.6	120	0.7	826	1.9
20 – 24	3850	14.2	758	4.6	4608	10.6
25 – 29	6240	23.0	2476	15.0	8718	20.0
30 – 34	5601	20.7	3694	22.4	9295	21.3
35 – 39	4138	15.3	3533	21.4	7671	17.6
40 – 44	2422	8.9	2200	13.3	4622	10.6
45 – 49	1511	5.6	1577	9.5	3088	7.1
50 – 54	982	3.6	793	4.8	1775	4.1
55 – 59	432	1.6	392	2.4	824	1.9
60+	483	1.8	376	2.3	859	2.0
NOT STATED	161	0.6	83	0.5	244	0.6
TOTAL	27073	100.0	16514	100.0	43587	100.0

Source : NACP Disease Control Unit, MOH, 2001

.FIG 1: REPORTED CUMULATIVE AIDS CASES IN GHANA BY AGE AND SEX
1986 – 2000



SOURCE: NACP Disease Control Unit, MOH, 2001

The female to male ratio which was 6:1 in 1987 has narrowed to 2:1 currently. All regions of Ghana have reported cases with the Ashanti Region leading with about 30% of all reported cases.

**Table 3: Reported Cumulative AIDS cases in Ghana by Region
1986 - 2000**

REGION	NO. OF CASES	PERCENTAGE (%)
ASHANTI	13,023	29.9
BRONG AHAFO	3,540	8.1
CENTRAL	3,061	7.0
EASTERN	6,939	15.9
GREATER ACCRA	6,416	14.7
NORTHERN	1,889	4.3
UPPER EAST	2,247	5.2
UPPER WEST	719	1.6
VOLTA	1,698	3.9
WESTERN	3,969	9.1
NOT STATED	86	0.2
TOTAL	4,3587	100.0

Source : NACP Disease Control Unit, MOH, 2001

These cases cover all age groups. The peak age for males is 30-34 years while that for females is 25-29 years. Ninety percent ((90%) of all reported cases are in the age range of 15-49 years. There are regional variations in the peak age group among the different sexes. About 60% of the regions are now reporting of peak ages among males in the older age groups (35-39 yrs). Again, the proportion of males who are reported in the age group beyond 35 years is increasing. In the early years of the epidemic, females were outnumbering males in all age groups except for the 5-9 years age group. This is an indication that older men are becoming increasingly infected and are probably infecting younger females as described in the "SUGAR DADDY SYNDROME". The lowest numbers have been reported in the 5-14 age group which has been described as the "window of hope". The reference to this group as such stems from the fact that majority of them may not be sexually active and therefore advantage could be taken to influence their sexual behaviour when they eventually become sexually active. The most predominant mode of transmission is heterosexual sex which accounts for about 80% of

the infection. Vertical transmission and transmission through blood and blood products account for 15% and 5% respectively. It is to be noted that the proportion of cases resulting from blood and blood products appear to be significant. This is because the proportion represents cumulative cases. Since 1990 when all blood prior to transfusion gets screened at all regional and district hospitals, there has been no evidence of infection through contaminated blood.

The adult prevalence of HIV is currently estimated at 4.6%. using the twenty-five sentinel sites scattered all over the country. It is estimated that about 500,000 Ghanaians are currently living with HIV or AIDS. Prevalence among commercial sex workers in Accra/Tema and Kumasi were estimated at 75.8 and 82% respectively in 1998. Among STD patients the prevalence in Accra and Kumasi respectively stands at 33% and 17%. This is not unexpected as the former are known to be at a much higher risk and therefore considered as core transmitters.

There are indications that the number of cases will increase as seen from the figures from the Korle-Bu Teaching Hospital.

Table 4: Records of AIDS Cases and Death 1991 – 1999 Korle-Bu Teaching Hospital

Year	No. of AIDS Cases	No. of AIDS Deaths
1991	49	7
1992	130	38
1993	272	112
1994	322	96
1995	597	132
1996	705	181
1997	795	214
1998	1,045	246
1999	1,159	276
2000	1,524	295

Source: Medical Records – Fevers Unit Korle-Bu Teaching Hospital 2000

Awareness about HIV/AIDS is almost universal in both urban and rural settings as well as among the literate and illiterate. This has however not translated into the desired behaviour change as only 16% of men and 6% of women claimed to have used a condom in their last sexual encounter as reported from the 1998 Ghana Demographic and Health Survey. The level of personal risk perception remains rather low. Only 58% of young adult males in 1999 perceived themselves as being at risk of being infected with HIV. This situation presents a great challenge to the national efforts at prevention and control.

AIDS has now become the leading cause of death of the infectious and parasitic diseases admission in Korle-Bu Teaching Hospital, as shown by the information obtained in 1996 even though malaria remains the No. 1 cause of admission.

Table 5: Number of Admissions for Infectious and Parasitic Diseases KBTH, 1996

Disease Category	Total Number of Cases	Deaths	% Case Fatality
Malaria including cerebral malaria	995	54	5.4
Tuberculosis	461	76	16.5
HIV/AIDS	278	166	59.7
Diarrhoea and Gastro Enteritis	255	26	10.2
Septicemia	140	21	1.4
Typhoid Fever	132	14	10.6
Tetanus	57	27	47.3
Viral Hepatitis	41	7	17.1
Amoebic liver abscess	34	5	14.7
Measles	5	0	0
Other infectious and Parasitic Diseases	252	16	6.3
Total	2,650	412	15.5

Source: Biritwum et al. in Ghana Medical Journal, Vol. 34 No 4 Dec 2000

1.4 National Response to HIV/AIDS

1.4.1 Government Response to HIV/AIDS

The national response began in 1985 with the setting up of The National Technical Committee on AIDS (NTCA). This was replaced with The National AIDS/STD Control Programme (NACP) based at the Ministry of Health in 1987. NACP has been the co-ordinating body of the national response even though it is situated in the Ministry of Health until September 2000 when the Ghana AIDS Commission was inaugurated. The national programme has pursued one short-term and two short-term plans since its inception. It is currently pursuing a 5 year National Strategic Framework. The objectives of the plans have been to reduce further transmission of infection and to mitigate the effects of HIV/AIDS on the infected and affected. Priority interventions have focussed on promotion of safe sex, condom promotion, improved management of STDs, safe blood, infection control, nursing/clinical care and counselling and home based care. The context of the response has been multisectoral, multidisciplinary and expanded. Stakeholders have included government sectors, private sector, NGOs, traditional healers, persons living with HIV/AIDS (PLWAs) and civil society.

1.4.2 Promotion of Safe Sex including Condom Promotion

Since 1985, there has been public education on the epidemic. The initial phase concentrated on general information aimed at equipping members of the public with information on modes of transmission and prevention of infection relating to sexual transmission. This focused on promotion of abstinence, mutual fidelity, avoidance of

casual sex and correct, consistent use of condoms. The current emphasis of the education has focused on personalizing the epidemic for people to adopt positive behaviour change.

Condoms are currently the only tool for protection in persons who cannot avoid casual sex or sex with multiple partners whose HIV status is unknown to them. The programme has been promoting condom use and improving its distribution through social marketing as well as through outlets such as fuel stations. Peer distribution has also been used among sex workers, miners and artisan apprentices. The female condom which is supposed to provide protection for females whose partners are unwilling to wear male condoms was recently introduced into the country. It will be distributed along social marketing lines and the promotion would address misconceptions that people have about it. The price has been pegged at three hundred cedis. This would ensure access and also sustain supplies.

1.4.3 Improved Management of Sexually Transmitted Diseases (STDs)

STDs have been shown to facilitate the acquisition and transmission of HIV. Proper management therefore indirectly reduces one's risk of acquisition of HIV. To achieve this, the Ministry of Health has adopted the syndromic management approach which enables treatment to be offered at as low a level as possible without the use of laboratories. This clears infection fast and renders the patient non-infectious. The most efficacious drugs have also been incorporated into the essential drug list and is widely available at all health facilities. To ensure the proper use of the syndromic management approach, training has been offered to a wide range of providers including doctors, medical assistants, pharmacists and some family planning nurses.

There is a special focus on sex workers for whom a programme that provides counselling, STD care and condom distribution is in place. This programme initially began in Accra/Tema but has since spread to other cities and areas where sex work is more prevalent. A programme for the uniformed forces has also been established to prevent transmission among the members as well as their families.

1.4.4 Clinical Management and Care

Infected blood is the most efficient mode of HIV transmission. Blood products such as plasma and other tissues such as bone marrow also have the potential of transmitting infection. As a policy therefore, all blood is screened for HIV prior to transfusion. Guidelines on rational use of blood transfusion are also in place to reduce the incidence of unnecessary transfusions.

Unsafe practices such as sharing of needles and other sharp tools such as razor blades could also lead to infection. To overcome this, there is extensive education coupled with regular supplies of needles and syringes in all health institutions. Training has been organized for a number of health care workers as well as traditional practitioners to practice universal precautions while attending to patients.

Clinical management has mainly been for opportunistic infections but lately a few people have been on anti-retroviral therapy. With technical and financial support from UNAIDS, a continuum of care package has been elaborated. A consultative and consensus building meeting has been held to agree on how to establish this in the various regions and districts.

Increasingly, the potential of Persons Living With HIV/AIDS (PLWHAs) is being harnessed. Through the support of one of our NGO partners, PLWHAs are being supported to form associations through which funds will be channelled to support income generation activities. They are also represented on a number of committees to give their perspectives of how to make progress. Some communities are also being taken through a process that will empower them to support care of infected individuals.

1.4.5 Counselling

This strategy remains the key towards support for the infected and affected. It is offered prior to testing and after the test. Especially for the infected individuals counseling provides psychosocial support and hope. Through counseling, they are able to lead a more positive life. To date over 600 counselors have been trained all over the country to provide this service in health institutions. Some NGOs have also received training in counseling for their members with the view to expanding the scope and coverage of counseling and make voluntary counseling and eventual testing widely available.

1.4.6 Advocacy

There is a surveillance system for both HIV and AIDS. The HIV surveillance focuses on an annual sentinel sero surveillance at twenty five sites countrywide. This is to help follow trends of the epidemic over time. Plans are far advanced to complement the sentinel surveillance with behaviour surveillance. This will provide some insights into the changing trends. AIDS surveillance with all its limitations is still useful in providing an insight into the burden of disease and to plan what it takes to provide adequate clinical management.

The information derived from the surveillance system has been used to develop the advocacy tool. Advocacy and capacity building have been crucial in the response. In the bid to expand the national response the programme has had to do a lot of advocacy to emphasize the need for everyone to play a role. This has been done with an advocacy tool " The AIDS Impact Model (AIM) ". This has been supplemented with an accompanying booklet "HIV/AIDS in Ghana ".

As we all know, traditional authority in Ghana has a lot of influence. Already, the Asantehene has taken the initiative to mobilize his subjects to confront the epidemic. Efforts are being made to meet with the National House of Chiefs to discuss their role in the national efforts. Consultations have already taken place to put this initiative within the District Response Initiative context.

1.4.7 HIV/AIDS Policy

A national policy is currently being finalized and is expected to provide among others policy direction and an enabling environment for the pursuit of the various interventions. The document has already been taken through consensus building and is expected to be ratified soon. The draft National HIV/AIDS and STI policy required that the Ministry of Employment and Social Welfare develop a comprehensive policy on employment related HIV/AIDS issues.

The policy also states that HIV/AIDS testing shall not be part of mandatory pre-employment examination in addition and that “HIV/AIDS patients shall not be obliged to disclose their status to their employers or prospective employers”.

1.4.8 Expanding the Response to Include the Private Sector and Initiatives at the District Level

Private sector involvement continues to preoccupy the national programme. A study of HIV/AIDS and the workplace was undertaken in 1998. This has formed a basis for the formulation of workplace related programmes. Already some private sector enterprises have begun programmes and others are being encouraged and supported to put in place their programmes.

District Response Initiative (DRI) also seeks to take advantage of the decentralization and the unique position that District Assemblies find themselves is being pursued as a strategy to expand the national response and also to mobilize more resources from the local levels. To date, twenty seven districts are being supported to develop their district specific plans.

1.4.9 Research

Research continues to be an important aspect of the national response. A number of researches have been undertaken to guide programming. Others are currently on-going including the validation of claims of herbal cures. This is being done in collaboration with the federation of traditional healers who have lately become one of our allies. Planned research includes a behaviour surveillance survey which in conjunction with our prevalence surveillance will start providing some insights into some of the trends that are emerging.

1.5 Rationale and Objectives

In recognition of the possible consequences of HIV/AIDS on business concerns a desk review of existing data on the economic impact of AIDS on firms and business in Ghana was carried out in collaboration with the POLICY Project, Accra, Ghana in September – October 2000. This review concluded that the full impact of HIV/AIDS on the private

sector was not yet visible and the situation could be attributed to the fact that the country was still experiencing the expansion of the HIV epidemic rather than the AIDS epidemic.

Therefore, firms are yet to experience the impact of HIV/AIDS at the workplace. The study concluded that in order to ascertain a demonstrable effect of HIV/AIDS, an in-depth study of the disease on business was required.

Therefore, the National AIDS Control Programme with the support from the Policy Project commissioned the study to assess the current economic and social impact of HIV/AIDS in the workplace and to determine how the epidemic in the long term will affect businesses in the country.

The major objectives of this study are therefore to;

- i. Establish whether evidence exist to suggest the effect of HIV/AIDS on particular businesses.
- ii. Ascertain the workplace policies on HIV/AIDS in different settings.
- iii. Review existing workplace HIV/AIDS and make recommendations for improvement and or extension to other business houses.

2.0 METHOD OF STUDY

2.1 Selection of Companies to be Studied and Data Collection Tools

2.1.1. Selection of Companies

The target groups for this study were companies with a sizeable workforce in the Greater Accra Region. This was to enable the study team have easy access to the workers and since this was a preliminary study, it was necessary to have companies that one could visit readily. The selection of the companies was guided also by the availability of the Companies' own medical facilities. This was necessary in order to obtain Company specific information on health. This is due to the fact that a number of Companies do not have their own clinics and employees used both public and private contracted health institutions. Retrieving Company specific data on HIV/AIDS therefore could have been a daunting task. For the purpose of this study, the companies have been identified as company A, B and C.

Two sensitization meetings were held with the private sector at the beginning of the study. First with the members of the Ghana Employers Association at their first meeting for the year 2001 on March 15th 2001, and with the Private Enterprises Foundation on March 17 2001.

The purpose of the sensitization was to inform them about the current state of the epidemic in Ghana and in Southern Africa. This was to draw their attention to the effects of HIV/AIDS on business in the Southern Africa, share with them the difficulty of the desk review and the fact that there was a dearth of information on how HIV/AIDS was

affecting business in Ghana, hence the need for the current study and similar ones in future and also to solicit their co-operation and support in carrying out this study.

The Executive Director of the Ghana Employers' Association wrote a formal letter of introduction to the Chief Executive Officers of the three organizations studied asking for their co-operation with the research team on the study.

The Manager of the National AIDS Control Programme (NACP) in addition also wrote a letter introducing the study team and also detailing the data requirements for the study and soliciting their assistance.

2.1.2 Data Collection tools.

Quantitative and qualitative methods of data collection were utilized. Records from the companies' clinics were reviewed in order to determine the numbers and disease patterns seen at the clinic for the period 1990 to 2000. Also reviewed were the number of HIV/AIDS cases seen over the same period. The cost of treatment for persons with HIV/AIDS was analyzed. Data on number of deaths, funerals costs, recruitment and training costs as well as absenteeism were reviewed. Also examined were available HIV/AIDS prevention programmes, key informant interviews and focus group discussions, which were, conducted with management and staff respectively to ascertain their knowledge and attitudes the possible economic and social impact of HIV/AIDS. Employees' knowledge and attitude towards people with HIV infection were also investigated. A structured questionnaire was used for data collection.

2.2 . Limitations of Study

This study had anticipated a number of difficulties given the sensitive nature of some of the information that had to be collected. Hence the sensitization of relevant authorities before the start of data collection. In spite of this, members of the study team had major difficulties in retrieving the relevant data from the various businesses studied.

The problems were:

- i. The financial data was a very sensitive piece of information and so only the health care expenditure could be obtained readily. As at the time of writing the report the other financial data such as training costs, funeral costs, etc. is yet to be made available.
- ii. There was insufficient data on the number of AIDS cases and the level of absenteeism.
- iii. A number of Senior Managers were not sure about their companies reaction to their given such sensitive information even though the relevant letter for permission had been sent through the Chief Executive.

In future to obtain useful data, there is the need for NACP to negotiate with a few business concern and have them agree to collect prospective data (on a regular basis) on the parameters required for determine the Economic impact on those businesses. The information obtained should be seen as privilege information and in order to inspire confidence for more studies to be undertaken care would have to be exercised on who or which team does this work. This notwithstanding the information obtained has been insightful.

3.0 FINDINGS

3.1 Profile of Selected Firms

The firms studied were from the manufacturing, banking and cargo handling industries. Each had a workforce which included permanent staff and casuals. The casual workers were hired during the peak season of work or when some of the employees were on sick leave. This practice ensures that for the parastatal organization, during the peak period of work which is October – December there is adequate labour for the work which is tedious. Indeed, due to the nature of the work involved in cargo handling the use of casuals with its attendant problems is higher.

The three companies together employ an estimated work force of 8,500.

3.2 Situation of HIV/AIDS at the workplace

Substantive data do not exist in most workplaces to show the number of employees with HIV and AIDS infection.

One of the Companies has had only one person known to have had AIDS. That person was said to have died last year. The other two companies have begun to see increasing number of staff and dependants who have tested HIV positive. The number of employees with AIDS who have been cared for has shown a relative increase.

Since 1996, the doctor in charge of facilities in Company A has recorded more than ten HIV positive employees yearly.

Table 4: Number of HIV/AIDS Cases Seen in Health Facility of Company “A”

Year	Number of Patients Screened	Number of HIV Positive
1996	42	13
1997	35	38 ?
1998	124	22
1999	200	63
2000	214	65

Source: Medical Records of Company “A”.

They were aware that some of the workers had been diagnosed with HIV infection but apart from the doctors who know the names of the patients the rest of the management did not know who had or did not have AIDS in the Company.

**Table 5: Number of Cases of AIDS and Deaths in Company “B”
1990 – 2000**

Year	No. of AIDS Cases	No. of AIDS Deaths
1990	1	1
1991	1	1
1992	-	-
1993	1	-
1994	2	1
1995	-	1
1996	1	1
1997	-	-
1998	1	-
1999	7	-
2000	14	4
Total	29	10

Source: Medical Records of Company “B”

There are indications that the number of cases will increase as seen from the figures from the Korle-Bu Teaching Hospital. (See table 4)

3.3 Health, Medical and Benefit Practices

The three organizations have medical facilities with doctors and other health workers employed to provide health care for the workers. One of the clinics was on site and the two others were within reach of the workers.

In the regions where there are no company clinics workers attend clinic at the employers chosen facility. All the workers were expected to attend these clinics with any kind of illness when an employee falls sick. An employee's medical bills are reimbursed when they attend public health facilities outside the working hours of the clinic.

None of the organizations studied had a health insurance scheme. The other health related benefits offered to employees were similar and conformed to those prescribed by the labour laws of the country.

All employees contributed to the National Social Security Scheme. The package of this scheme includes the following:

- Retirement Scheme
- Disability Scheme
- Death in service benefit.

The package of this scheme is paid to workers irrespective of the cause of ill health. In reviewing the pattern and trends of utilizations of health service, it was found that the utilization rate since the start of the epidemic as judged by attendance since 1991 has not changed very much. (Table 6).

Table 6: Attendance at a Medical Facility in Company "C" 1991 – 2005

Year	No. of Attendance
1991	3619
1992	3774
1993	3638
1994	3817
1995	4236
1996	4306
1997	4419
1998	4073
1999	3889
2000	3743

Source: Medical Records of Company "C" ,

The type of illnesses seen at all the clinics are not different from those seen in the public health facilities in Ghana. Malaria is the leading cause of attendance at all the clinics.

The clinics have not seen any appreciable increase in the health care expenditure taking into consideration the depreciation of the cedi. The Health Care Expenditure from one of the companies illustrates this point. (Table 7)

Table 7: Annual Medical Care Cost for Drugs and Laboratory Services for Company “A” 1996 - 2000

Year	Total Annual Cost in Cedis
1996	83,845,909*
1997	535,927,514
1998	616,372,971
1999	589,815,326
2000	788,479,424

* For October – December 1996 only

Source: Health Expenditure Records, Company “A”

3.4 Organizational Policies and Policy Processes

All the organizations visited have policies that enable them have workplace programmes on health issues including HIV/AIDS.

However, only one of the companies has a specific HIV/AIDS policy written out. This policy has been in use since March 2000. To have a policy in place, the Human Resources Director had an awareness meeting organized as part of the company’s durbar with the workers. This was a meeting at which all the workers, both junior and senior staff including management were present and how the company would be affected. The discussions were received positively by all. Subsequently, there were meetings between the representatives of the Trades Union and Management. It was agreed that the company must have a Policy on HIV/AIDS so the worldwide HIV/AIDS policy was adopted.

All the three organizations do have health related criteria for hiring employees and simply stated this “requires that the employee is in a good health status and is medically fit for the work he has applied for”.

The organizations’ medical doctors who are the advisers in all matters relating to health, conduct pre-employment medical examinations on the employees. Their responsibility is to determine whether the prospective applicants are medically fit or otherwise. They also conduct periodic medical examinations on the workers even after they have been employed.

There are no strict laid down criteria for hiring workers. The only requirement is that the person is in good health. None of the organizations has health related criteria which disqualify a person with HIV infection or AIDS from being employed.

None requires prospective employee to submit to HIV testing {mandatory or voluntary}. Indeed HIV is not part of the required medical tests one has to undertake. The organizations are required to provide medical facilities for the employees. All the companies require that medical information is treated as confidential. This rule applies to

all health conditions. The medical record of the patients containing information relating to HIV/AIDS is known to only the health staff and not Management of the companies.

Medical Facilities

The provision of medical facilities is one of the requirements that organizations have to oblige with. A typical example reads “The employers will provide free medical attention to the employee. Such attention, whenever possible, will be at the company’s Medical Centre. When it is not possible for the employee to attend the medical centre, it may be at the local/urban health facility and or such other recognized medical practitioner or clinic.

Bills for such emergency treatment under circumstances as mentioned above shall be paid or refunded by the employer subject to the approval of the company doctor.

Maternity, dental and optical treatment shall not be provided by the company except where the disease or injury arises from the employment.

The company shall reimburse all medical expenses incurred on the employees’ registered spouse and children up to 21 years if in full time education; and not married and not working”. The policy does not require that HIV/AIDS related differently from all other illnesses and should therefore not be treated differently from all other illnesses. In conformity with this policy, none of the Management talked to has required that HIV/AIDS related illness be treated differently to date.

All the organizations have provisions about what to do if an employee is no longer able to work at normal capacity due to a health condition. These provisions are spelt out in the collective bargaining agreements. These provisions are the “sick leave and Retirement on Medical Reason”. The sick leave has the following provisions:

An employee who has completed his probationary period and is absent from work due to sickness shall be granted sick leave on the following basis.

- (a) 3 months service but less than three years.
 - 2 months full pay
 - 2 months $\frac{3}{4}$ pay
 - 2 months $\frac{1}{2}$ pay

- (b) 3 years service but less than six years.
 - 3 months full pay
 - 3 months $\frac{3}{4}$ pay
 - 3 months $\frac{1}{2}$ pay

- (c) 6 years service and above
 - 4 months full pay
 - 4 months $\frac{3}{4}$ pay

- 4 months ½ pay

These demands shall only be made in cases where sickness is supported by a medical certificate.

Almost all Ghanaian workplaces have similar provisions and the Collective Bargaining Agreements are reviewed every 2 – 3 years. In the event that the employee is no longer able to work he/she can retire on medical grounds. “Retirement on Medical Reason granted for an employee who becomes physically unable to continue his employment shall leave the service of the employer on medical grounds on the production of a certificate from the company’s doctor or subject to the confirmation of the company’s doctor, or certificate from a recognized medical practitioner.”

An employee leaving the service on medical grounds shall be entitled to superannuation benefit under the social security scheme and a gratuity calculated on twelve week’s pay for each year of service”.

In all the organizations visited the usual practice for retiring an employee on medical grounds required that a Medical Board is constituted to ascertain that the said employee is not able to work and it is recommended for his employers to allow him to retire on medical grounds.

All the organizations studied have not had to retire any employee with HIV infection or AIDS due to medical grounds. Indeed, management has not been officially informed about such workers.

3.5 Prevention and Education Practices

The Study found that in all the three companies semblance of workplace HIV/AIDS programmes were in place. However, they differed in scope and the way they are organized and funded.

In two of the companies HIV/AIDS was part of Occupational and Health Safety activities and not discrete programmes. From time to time workers were given talks on HIV/AIDS by invited persons and AIDS educational materials from the National AIDS Control Programme were distributed. HIV/AIDS issues also featured in the Companies newsletters.

However, the content related to how AIDS is spread and how it could be prevented. None of the articles discussed how AIDS would affect the particular organization. One of the companies has started a workplace programme since March 2001. The Programme to date has trained twenty five peer counselors at the workplace. These are volunteers drawn from all the departments and Units of the company.

Workers are provided with condoms for free on request at the Company’s clinic, but in order not to encourage abuse of this facility, provision has been made for the MCH Unit

of the Ministry of Health to sell both female and male condoms to the workers at the Company's premises fortnightly. This is well patronized by the workers.

The employees are given time off to participate in HIV/AIDS education during working hours.

The Company provides treatment for STDs at the Company's clinic for free yet very few employees report to the clinic with STDs. Voluntary Counselling and Confidential HIV Testing is on offer and so far only two employees have availed themselves to this facility.

All employees receive these services. It is management's hope that the peer counselors will extend the education to their family members, dependants and the community in which they live.

The employees interviewed have found the workplace programme beneficial. There is high awareness about HIV/AIDS among the workers and they believe it is too early to say whether it has made an impact on their lifestyles.

At a recent meeting with the workers in April this year, Management has assured the employees that HIV and AIDS related illnesses will be treated like any ill-health condition and will not be a reason for terminating any one's appointment.

The other two company doctors were worried that even though Management is generally supportive of workplace programmes on HIV/AIDS, they are not sure whether "HIV/AIDS will not be used as a cause for retrenching workers". This is because in the past a number of workers had been unhappy about the continuing presence of a worker with "Tuberculosis who was cured" and agitated for his removal. Even though this was resisted by Management, they are not sure what will happen. One could reason that in the case of HIV/AIDS, the possibility of an infected worker being sacked may most likely emanate from agitation from other workers (if they get to know) rather than from Management.

3.6 HIV/AIDS Effect on Companies

The Health care costs were the most visible and direct costs of the epidemic to the companies.

Since 1999 the number of HIV infections seen in one of the clinics has risen from 6 to 12 in the year 2000. Currently, the clinic provides care for nineteen (19) known people living with HIV/AIDS. The cost of out patient care {which includes drugs and laboratory services} to the Company ranged between ₦36,308 and ₦380,350 (per episode of illness).

Case Study 1

Mr. “D” reported at the Company’s clinic with the following symptoms; general weakness, anorexia, diarrhoea on and off and repeated attacks of fever on 7th March 2000. After a thorough history and examination the company doctor suspected he may have HIV infection. He requested for HIV antibody tests, which was positive. Between March 2000 and April 2001 Mr. “D” has been seen at the clinic ten times with different complaints. The total cost of drugs and laboratory test conducted on him is ₦1,894,900.00. It cost the company approximately ₦189,490 per each episode of illness.

Madam “E” reported at this same clinic with similar symptoms on 19th October 2000. The company doctor ordered on HIV antibody test, which turned out to be positive. Since October last year till March 2001. Madam “E” has reported to the clinic 11 times, each time with a different set of complaints.

The complaints include urinary tract infection, vaginal discharge, multiple boils, conjunctivitis anorexia, easy fatigability. The total cost of tests and treatment to the Company is ₦4,164,830 ie. ₦380,530 per episode of illness.

Currently, none of the companies provides anti-retroviral drugs. The drugs prescribed, were “essential drugs” for HIV-related illnesses. In spite of this data on cost of care so far provided to a number of HIV/AIDS employees in Company A presented in Table 7 suggest high losses to the Company.

Table 7: Cost of Treating HIV/AIDS Employees from Company “B” 1999 – 2001.

Index Number of Patient	Number of episodes of illness	Total cost of [care] Drugs and Investigation {in cedis}	Average Cost per episode of illness {in cedis}
001	4	145,230	36,308
002	7	2,350,670	335,810
003	10	1,894,900	189,490
004	8	1,113,800	139,225
005	21	1,291,610	61,505
006	8	361,340	45,168
007	2	170,380	85,190
008	6	456,470	76,078
009	6	1,540,000	256,667
010	11	4,185,830	380,530
011	5	1,330,960	266,192
012	4	1,288,440	322,110
013	2	251,620	125,810
014	6	370,110	61,685
015	8	297,610	37,271
016	6	534,910	89,031

Source: Health Expenditure Records from Company “B”

For this Company the expenditures for the known AIDS cases were almost eighteen million cedis (₵18,000,000) which averages almost (₵160,000.00)One hundred and sixty thousand cedis per each episode of illness for a two year period.

One of the companies has clearly stated that as a rule it would not provide anti-retroviral treatment. This is because given the current prices for anti-retroviral treatment, the cost to monitor patients’ progress and side effects, providing this treatment is not an option that can be sustained by the Company in the long term.

The company is, however, committed to provide “essential drugs” for HIV-related illnesses. Anti-retroviral therapy is keeping HIV Positive people alive longer. However, a major drawback to its accessibility is the cost of the drugs. The cost of a defined daily dose of anti-retrovirals in Ghana is estimated at ₵105,000. Currently, only 5 patients attending the Fever’s Unit Clinic at the Korle-Bu Teaching Hospital are on these drugs.

They pay ₵3 million cedis monthly for these drugs alone. The cost of laboratory investigation to monitor the viral load and the CD4 lymphocyte count (these are investigations that must be conducted on all patients on anti-retroviral drugs) cost ₵1.7 million cedis for the two tests.

This kind of cost clearly is unaffordable by most companies. The cost that one local organization has had to bear since last year when one of its employees infected with HIV was put on anti-retroviral drugs provides food for thought. {Case study 2}.

Case Study 2

Mr. “X” is forty-six years old, married with three children and works with an organization in Accra. He was referred to the Korle-Bu Teaching Hospital on 31st May 2000 because he had been ill on and off without any improvement for the past one year.

His symptoms and signs were suggestive of HIV infection. A laboratory investigation done on 2nd June 2000 confirmed his HIV positive status. He was counselled and his wife was also counselled and tested to determine her HIV antibody status. She was HIV negative.

Mr. X was put on anti retroviral treatment in July 2000. Below is his health care cost from July 2000 to date. (Table 9).

Table 9: Health Expenditure Incurred on Mr. X from July 2000–May 2001

Date of Attendance	Cost of Drugs in cedis	Cost of Investigations in cedis	Total cost in cedis
5/7/2000	3,115,000	1,946,000	5,061,000
2/8/2000	3,115,000	56,000	3,171,000
4/9/2000	3,115,000	1,946,000	5,061,000
4/11/2000	6,230,000	-	6,230,000
11/1/2000	6,230,000	-	6,230,000
8/3/2001	6,230,000	1,575,000	-
Total	28,245,500	5,523,000	33,768,000

Source: Fevers Unit, Korle Bu Teaching Hospital

His condition has improved considerably and he is back at work.

The nine month treatment has cost his organization roughly ₺33.7 million cedis. That is an estimated ₺3.8 million cedis monthly. Obviously, this is a cost that even the most prosperous company can ill afford.

The only organization from which the health care cost (for treating PLWAs) was readily available showed the company had spent a total of ₺17.7 million on the sixteen persons, that is ₺155,306 per episode of illness.

Due to unavailability of data the other important costs such as HIV absenteeism, funeral costs, could not be computed.

If the company had decided to put the sixteen patients on anti-retroviral therapy it would have cost the company ₺339,150,000 as against the current ₺17 million cedis. This would have been almost 40 percent of the health care expenditure of one of the companies studied.

4.0 ATTITUDE TO HIV/AIDS AT WORKPLACE

Introduction

Focus group discussions were held with different groups of workers in two of the three companies studied. In the first company, two groups of workers i.e., female clerical staff and male casual workers were interviewed separately. In the second company, three groups of workers were met separately. These were male workers drawn from the various units of the company, female workers and supervisors from some of the units. The purpose was to find out the attitude of the workers towards HIV/AIDS.

4.1 Daily Health Concerns

Each group was asked about the kinds of illnesses that they normally thought about and were interested to guard against. In the first company, the concern of the female clerical staff was with respect to tuberculosis, headache and malaria. The male casual workers also mentioned malaria, fever and bodily pains. In the second company, sicknesses mentioned included headaches, fever, malaria, coughs, waist pains, bodily pains and catarrh. It was learnt that these were thought to be health problems that were commonly reported to the company's clinic and were considered to be associated with the kind of work they do at the workplace. What this means is that none of them readily thought of HIV/AIDS as a health problem of first priority.

4.2 Knowledge of HIV/AIDS and its bother to Workers

They were then asked about their familiarity with HIV/AIDS. Although all members of the two groups in the first company that participated in the discussions knew about HIV/AIDS, majority of them did not know about the difference between HIV and AIDS. One female, however, explained that when one is said to have HIV, it means, "He/she is a

carrier of the AIDS disease but when one has AIDS, then it means the person is infected”. Even here, it was not too clear as to what her understanding was.

Another female staff was of the opinion that only health workers are in a position to know the difference between HIV and AIDS. As she put it, “I am not in the medical field, so I can’t tell the difference but I know there is AIDS”.

When the same question was put to the men in this company, these were some of the responses:

- “Somebody can have HIV but it cannot be detected. On the contrary, AIDS shows symptoms and by the time AIDS shows up the person would be on his way to die”
- “HIV leads to AIDS”.

In the second company, all the participants had heard about HIV/AIDS. At the same time, all but one of them had some knowledge about the difference between HIV and AIDS. One of them explained the difference this way: “HIV is just the situation where the body soldiers are fought by the virus. AIDS on the other hand, is where as a result of the virus infection the body breaks down and is open to all diseases”. Knowledge about HIV/AIDS was high among workers interviewed in this company relative to the first.

They were also asked the extent to which HIV/AIDS bothers them. The responses of the women in the first company showed that although most of them considered it a “killer” and frightening” disease, some of the married ones did not think it is any big problem as they did not see how they would be infected being in a stable marital union. As one of them put it, “It does not worry me because I am in a stable marriage and I am sticking to my partner”.

Some of them, however, disagreed when the issue was discussed further and their colleagues drew their attention to the other means by which they could be infected. According to one of them, her fear was in respect of tools that may not be sterilized after they have been used on several persons in a hairdressing saloon. Getting infected from infected blades and needles (as for example through injection) was also pointed out. One of them then drew attention to the fact that although women may be in stable marital unions, they may still be at risk since most men, according to her, are not faithful to their wives when it comes to sexual matters. This view was overwhelmingly supported by almost all the women who blamed the spread of the AIDS virus on the sexual promiscuity of men irrespective of their marital status.

What came out of the discussions at this stage was that many married women think HIV/AIDS is not a problem for them until their attention is drawn to what unfaithful sexual relationship on the part of even one partner could lead to. In the case of the men in the first company, many of them said their concern about HIV/AIDS stemmed from their knowledge that it is a killer disease and to date has no cure. It thus, puts everybody at a risk. One of them for example, advisedly said “Death would one day come, but why don’t you play it safe so that you will die in dignity?”

In the second company, many of them said that, under normal circumstances, they hardly think about it as a bother until they watch television advertisements or listen to talks on the disease either on a radio, television or at a forum. Some of them had the following to say:

- I get bothered only when issues about it are being discussed or when watching T.V. showing adverts on AIDS”
- “I am not bothered but I show concern because it is always being preached on the T.V. and radio”
- Personally, I am so occupied in such a way that it scarcely bothers me”
- “It is a problem especially when you hear of the numbers infected, because those who have it and have not been reported could be more”
- “What bothers me is that it looks like the youth who are the future leaders are the most affected”.

Some of the workers in the second company again talked of their experience or encounter with persons who had AIDS but who have since died. These people expressed more concern and thought one ought to be on his/her guard because as one said “Any little mistake I make can result in my getting the disease as for example from a hair dressing saloon”.

4.3 Impact of HIV/AIDS Campaigns

In response to the question as to whether some of the advertisements on the radio and television have helped change the behaviour of some of their colleagues, the following were some responses by the women in the first company:

- “Use condom advertisements mean I can go in for women and use the condom but the condom can burst”.
- “Some men say that AIDS is an old disease which has been given a new name. They say all die be die. I even know a male doctor friend who says that AIDS is an old disease”.
- “Most of the women here are married and it is rather the young ones who should be the target”.
- “The women are more careful than the men because they think more about their children”.
- “Most of the women we interact with scarcely talk about HIV/AIDS”.

These suggest that HIV/AIDS campaigns have not made much impact. It is also clear that most women consider men as the main culprits in the spread of the disease. It is also worrisome to learn that a medical officer will express an apparent lack of concern under the philosophy that “AIDS is an old disease”. It is again not pleasant for some married women to have the notion that they are not at risk once they are in a stable union.

It was also found that most of the workers in this company have not seen an AIDS patient before apart from the few shown occasionally on some television programmes. One woman, who said she had seen one AIDS patient herself, demonstrated relatively more

concern than her other colleagues. This suggests that many people are not changing their sexual behaviour because many of them have not seen an AIDS patient before.

In contrast to the women, majority of the men in the first company were of the opinion that some of their colleagues have begun sticking to their partners while others have made sure they always go with condoms. Their worry, however, was with the fact that condoms can burst and expose the actors to risks of HIV/AIDS infection. At the same time, many men have reduced the number of their “girlfriends”, most of them claimed.

When asked as to who should be blamed i.e., men or women, the responses of the men in this company were mixed. While some of them thought it is usually the men who go to “chase” the women, some felt that

- “Looking at the economic situation, some women, though might be married, often yield to the temptation to have sex with richer men”.

The views expressed by workers in the second company were equally mixed. While some said some people were changing their behaviours, others said some are still adamant. For example, a health worker at the company’s clinic was convinced workers at the company were increasingly demanding more condoms than previously. One of them also said he has bought his own clippers to be used at the barber’s shop to avoid the disease. These are positive signs of behaviour change. However, some of them pointed to an apparent indifference on the part of many people. For example, some of them said, “Although some discuss it, others say that AIDS will help you to plan your life better because you will know that you are going to die soon”. Some people were also reported to be saying that, “even malaria kills so if AIDS kills you, it does not matter”.

It also came, as a surprise to hear some of the workers in the second company thinking that the AIDS problem was more serious among the rural as against the urban dwellers and felt the rural areas should be targeted for more HIV/AIDS education. Those who shared this view thought that many rural dwellers attribute HIV/AIDS to the wrath and curses of the gods on account of their relatively lower levels of education.

There was a call for more bill boards and advertisements on HIV/AIDS because the more people see and hear about the disease, the more they will sit up and change their behaviour. There should also be more T.V. discussions in the local languages such as that of “Mmaa Nkomo” on GTV.

4.4 Management Response to HIV/AIDS Infected Workers

They were further asked about what they thought Management of the company should do to protect the workers from contracting HIV/AIDS. To this, the women in the first company were of the opinion that Management should organize regular talks to them by experts. The men in this company, on the other hand, were of the view that the solution lies in increased remuneration to workers such that they would be able to cater for their partners very well to prevent them from falling prey to sexual advances from richer men.

It was learnt that Management once organized a talk on HIV/AIDS for the workers. This was, however, considered inadequate by the workers who wondered if they could not make such talks regular (i.e., every three months) to educate workers on the dangers of the disease and how to avoid being infected. On the part of the casual male workers, although they were aware that such a talk was once organized, many of them did not have the opportunity to attend. There were still others who did not even hear about it. It thus, suggests that management has no workplace programme on HIV/AIDS in this company.

The investigation also at this stage, probed into the reaction of the staff after the HIV/AIDS talk that was once organized at the workplace. To some of the women, many of the workers did not tell what their reactions were. However, they disclosed that upon hearing that the doctor in charge of the company clinic had made a statement at the forum to the effect that some workers had tested HIV positive, most of them were angry especially when they saw a publication of what the doctor was reported to have said in the media. The interpretation that can be made here is that people are not comfortable to be labelled to be among a group of people among whom there are persons who are HIV positive because of the stigma that has so far been attached to the disease. Yet, no one is expressing any serious concern about how to prevent its infection and spread in the first place.

Another question was what they thought Management should do upon finding that a staff member was HIV positive. To this, although most of the women in the first company were not too sure since it has not happened, many felt that the person should be allowed to continue to work until he/she cannot work any longer. Others were of the view that it would be a decision to be taken in consultation with the medical officer in charge of the company's clinic. The practice, as some of them explained, however, was that in extreme cases of ill health, one was made to meet with the Medical Board. In the case of HIV/AIDS, they felt it would raise a lot of uncomfortable questions among the other workers.

With reference to AIDS, some of the women in the first company premised their responses on their fear that sharing facilities at the workplace with such a person might lead to putting themselves into too much risk of HIV infection. Some of them therefore suggested that AIDS patients should be confined to the house or the hospital. Another said, "A suitable job schedule should be assigned to such a person so that he/she does not come into contact with other workers often".

One of them even thought working with an AIDS patient in an air conditioned office will put other workers at a higher risk of being infected and hence suggested that "AIDS patients should be allowed to come and work in the same office but not in an air conditioned office".

Another was concerned about the use of the lavatories together with AIDS patients and said, "The toilets should be disinfected any time an AIDS patient goes to use it".

On the other hand, some of the men were of the opinion that an AIDS patient

- “Must be sacked and compensated”.
- Another said, “Sack the person because it is an insult to the company”.

To such people, Management should sack the person with AIDS for fear that he/she would spread the disease to other workers at the company. Others argued differently as for example,

- “The person with AIDS should not be sacked because it is very disturbing and it would send the person to his grave faster. He also has to take care of himself and his family.

To many of the casual workers in this company, however, the reaction of Management would vary depending on the kind of worker involved. Others felt that Management decision would depend on the kind of investment Management has made in the training of whoever is the victim. In their view, if the person happened to be a casual worker, Management would not hesitate to sack him/her. They however, thought the company has no HIV/AIDS policy they are aware of what they considered was the practice was that when you are incapacitated, then Management would send you to the Medical Board or the necessary action”.

Workers in the second company were also unanimous on the view that Management should encourage any worker found to be HIV positive to continue to work till he/she cannot work again. According to one of them, “Management should encourage the HIV positive worker to work and not feel dejected. Sacking should not be resorted to because if the worker has other problems, he/she may commit suicide”. On the other hand, the general feeling in this company was that if he/she is found to be developing AIDS, then he/she should be confined to an area of work so that other persons would not be infected.

4.5 Workplace HIV/AIDS Policy

One of the companies interviewed was said to have an HIV/AIDS policy while the others did not have. For example, workers in the first company indicated that the company does not have any policy on HIV/AIDS that they are aware of. As one of them put it:

- “As to whether there is a policy or not, we don’t know. The issue of HIV/AIDS is a recent phenomenon. What we know is that a person is usually asked to see the Medical Board if he/she falls sick for about one year”.

It was, however, learnt from the second company that its policy on health according to the workers, suggests that if one is found to be HIV positive, he/she would be referred to the Health Unit for counseling and encouragement. What they considered to be of crucial importance is the maintenance of confidentiality in all matters relating to persons with HIV at the workplace. One worker in this company explained that, “If the public gets to know this, it would affect patronage of our products”.

On the company's policy on HIV/AIDS, it was explained that the company has selected and trained counselors in each unit to provide HIV/AIDS counseling for the other workers. Apart from these counselors who also work at the company, health workers from the Ministry of Health also come to talk to the workers on HIV/AIDS and sell condoms to them. All the counselors at the various units of the company have condoms, which their colleagues find very convenient to purchase their supplies. There has even been a new dimension to the company's HIV/AIDS programme where workers are now being encouraged to go for voluntary HIV testing at the company's clinic.

The voluntary testing according to some of them is, however, not good because "The moment you go for the test and you find that you are HIV positive, it may kill you faster because you would be thinking about so many things. But if you do not know you have it, you could still live happily till you develop the AIDS disease".

There were, however, others in this company who felt that those who do the test would in future be more careful about their lifestyle, i.e., those found to be negative. But if found to be positive, they were convinced one could die easily out of depression. One of them was of the opinion that "I would rather kill myself than to continue to live after I have been told I have AIDS".

It was also explained by one health staff of this company that they used to give condoms freely to the workers but now they sell them at reduced prices. This was because it was thought that when people are made to buy they would appreciate and endeavour to use them.

On the operation of the company's clinic, the female staff in the first company explained that there were no peculiar processes to follow. One would just have to report and be treated whenever he/she felt sick. The company's clinic, however, takes care of other workers who are not necessarily from this company.

On the contrary, the casual male workers in this company pointed out that they could not report STDs at the company's clinic for treatment because Management thought such diseases were not contracted while on the job. Therefore, if it were an STD, a casual worker would seek medical assistance outside the company's clinic. This policy therefore appears to be discriminatory against the casual workers.

It appeared both groups in the first company were in support of regular HIV/AIDS talks to workers at the workplace. They were therefore, asked about their preference regarding which person would make the largest impact in these talks. The responses were mixed among the women. Some felt that it would be better for an expert from outside the company to do the talking because when one is known among the staff, his/her word would not be taken seriously. Another felt that it should be the responsibility of the company's clinic doctor because "He/she is around and knows the lifestyle of the workers" and can thus address them better. Others thought both outsiders and persons within the company can jointly talk to them on HIV/AIDS.

On the part of the men, majority felt it would be better to have a trained staff member to lead such HIV/AIDS talks. The advantage, according to them is that since he is one of them, it would be relatively easier to organize the workers together for such talks even at short notices. Workers of the second company, however, considered the workplace HIV/AIDS programme that is currently, in place to be good and asked that it be continued. They also urged other companies to emulate their example.

4.6 The Socio-Economic Dimension of HIV/AIDS

One major area of interest was whether they thought HIV/AIDS was just a health or medical problem. The response of the females in the first company was that it was partly a health problem and partly an economic one because “A sick person is not very productive”. Another said “Low productivity is also as a result of absenteeism”. They also felt that at present HIV/AIDS is not affecting productivity but were convinced it would in the future “and that is why we are calling for a programme every three months or so to educate staff members on HIV/AIDS”.

The response of the males in this company was not too different from their female counterparts. They agreed that HIV/AIDS is not just a health problem “because the church is involved in it”. They also thought it would in future affect productivity if not checked because “morally, it breaks you down and you would not have the courage to produce more i.e., you would be demoralized”. They, however, did not think absenteeism has increased to the extent that it could be blamed on HIV/AIDS among workers. They were, on the other hand, convinced about the adverse impact of the disease on the company’s production performance and profit in future. As one of them put it “If people are having it (HIV) now, in the next two or so years, they cannot work well and that can affect productivity”.

Workers in the second company also agreed that HIV/AIDS is not just a health problem but affects all aspects of life, i.e., social and economic. It affects manpower and production as well. They were not sure if at present, HIV/AIDS was affecting the company’s profits but were convinced like their counterparts in the first company that it would in future. Health workers at the company’s clinic were, however, of the opinion that based on the increasing health costs the company has had to bear in recent times, HIV is having negative impacts on the company’s profits. This is due to the fact that the company’s health bills have increased tremendously.

4.7 Cure for HIV/AIDS

In either of the companies, it was found out that there are people who believe some traditional healers have got a cure for HIV/AIDS. As one of the workers in the first company put it, “I believe they have a cure because if they have found a cure for malaria, they can find a cure for AIDS”. Another also said, “Yes, because somebody even gave a testimony in church”. One worker in the second company on his part argued that, “The ‘Whites’ have not been able to use their machines to find the cure so their machines are

not capable of finding a cure for the disease. It is therefore, only the ‘Kwaem’ medicines (traditional or herbal medicine) that can cure HIV/AIDS”.

Others, however, felt the Ministry of Health (MOH) should throw a challenge to all those claiming to have a cure for AIDS to send the patients they claim to have cured to be tested at the MOH laboratories so that the debate over whether or not anyone has a cure for HIV/AIDS can finally be laid to rest.

4.8 Some Questions on the Minds of the Workers

They were given the opportunity to ask any questions that bothered them. The following came up among the women in the first company:

- Does sharing cups, spoons, bed, etc., with an HIV/AIDS person result in one getting infected?
- Does coughing spread HIV/AIDS?
- Does blood transfusion cause HIV/AIDS?
- If a lady has AIDS and is weak experiences her menstrual period, how should she be cared without the one caring for her not getting infected in the process?
- One woman expressed concern about her children getting HIV since they share a lot of things at school and asked how they could be protected from HIV/AIDS infection
- If a mother with HIV gives birth, what are the chances that the baby will also get infected?
- Do some of the blood groupings hasten HIV/AIDS infection among some people?

The following were questions asked by the men:

- What is the correct way to wear a condom to prevent them from bursting and putting users at risk?
- What do you make of people who appear on radios and television claiming to have a cure for HIV/AIDS?
- Some people argue that HIV/AIDS has been predicted in the Bible so it is bound to happen. What is your reaction to it?
- One of them also wondered why there is so much attention focused on HIV/AIDS although there are so many diseases, which kill faster than AIDS.

In sum, it is quite clear that members from the company that has HIV/AIDS policy and programme were more knowledgeable about HIV/AIDS than their counterparts in the other company, which has no HIV/AIDS policy and programme. It is therefore important that all companies institute some HIV/AIDS programmes for its workers as a matter of urgency.

5.0 DISCUSSION : SUMMARY OF KEY ISSUES

5.1 HIV/AIDS Effect on Companies

The general information collected on what is available (routinely collected by companies themselves) does not readily allow for the computation of the economic impact of HIV/AIDS at the workplace.

Most Companies are currently not aware of the magnitude or otherwise of the HIV/AIDS situation in their companies. For those companies that have HIV positive individuals the cost are insignificant. In a recent survey of businesses in thirty African countries, the two main impacts of HIV/AIDS on both the workplace and daily operations were “time lost to AIDS – related sickness” followed by “health care costs”.

In this study time lost to AIDS – related sickness was not apparent. This is not surprising for the current level of prevalence the country is probably experiencing HIV infection transmission primarily and it is still early to detect any serious effects. However, the review showed that sooner than later the “health care costs” will become apparent.

Some Observations

The extraction of sexually transmitted diseases (STD) cases proved a daunting task. Very few STD cases appeared in the medical records. In one of the clinics for the period 1998 and 1999 only 4 and 10 cases were seen retrospectively. It is difficult to believe that STDs do not occur among the workers.

Apart from the fact that STDs may also be asymptomatic in women in particular anecdotal information suggests that the reasons why most workers do not seek treatment may be found in Company guidelines for the provision of medical facilities. An explanation offered by one of the doctors was that there is a clause in the medical provision {one of the exemption clauses for treatment] that states that “... *treatment shall not be provided by the Company except where the disease or injury arises from the employment*”.

By convention this has meant exclusion for the treatment of STDs since it is seen as “self inflicted” and these diseases have not arisen “from the employment”

Engaging in unprotected sexual intercourse exposes a person both to HIV and to the classic Sexually Transmitted Infection. Therefore, reluctance to treat STDs will enhance HIV transmission. The presence of an unprotected sex as much as tenfold. Already, most people refer self treatment, however in effective to the inconvenience and embarrassment of seek treatment from a qualified personnel.

There is the need to remind managers that the sexual behaviours that lead to STDs also promote the spread of HIV. The inherent psychological barrier and the generalized custom of self-medication, which has characterized STD treatment and management

needs to be studied if efforts at effective STD are to be managed particularly for the major curable STDs, namely syphilis, gonorrhoea, chlamydia infection and trichomoniasis.

The above should also apply to all the casual workers which seems to be a feature of most companies.

5.2 Business Response to HIV/AIDS [Current and Future]

All the companies interviewed were of the opinion that HIV/AIDS is currently not affecting their operations. However, two of the companies have been appraised of what has happened in similar institutions in Eastern and Southern Africa and therefore have begun to take measures to forestall any possible effect.

One of the programmes is externally funded which seems to suggest that Management has not seen it necessary to invest its own internal resources to an HIV/AIDS workplace programme. This is cause for concern and it is hoped that once the programme takes off enough advocacy would be made to enable Management commit its own resources to the follow on programme.

There are a number of studies that have concretely shown that the presence of STDs increases the risk of HIV transmission during unprotected sex as much as tenfold.

The current programmes being implemented have not given enough attention to STD treatment and prevention. Present attitudes suggest that STDs are thought to be “self inflicted” and also arise from one’s social activities and employees have a responsibility for managing their STDs.

In future, awareness creation about STDs as a co-factor for HIV transmission and the need for early diagnosis and treatment would have to be given the same emphasis as HIV prevention. The Health Units need to incorporate all elements of STD prevention in the workplace programme. At the moment, condom promotion is the visible component of the STD prevention and treatment.

The collective bargaining agreements often known as “Negotiated Agreements and the Officers Rules and Conditions of service” for senior and junior staff respectively, discussed every two or three years, provide a good opportunity for addressing workplace programme on AIDS. Indeed, it can be a ‘negotiated item’. It would seem that this may be one of the possible ways to make management and employees make a commitment to HIV/AIDS in the workplace since it is in the interest of both parties that business is not affected negatively by HIV/AIDS.

5.3 Cost of setting up HIV/AIDS Programme at the workplace

It is important to acknowledge, “The first business of business is business”. Business must make a profit to survive, if not they disappear. Therefore, in setting up HIV/AIDS

programme, it is necessary to review the available company resource that can be effectively used before putting ourselves on for additional resources.

Peer educators and counsellors who are part of the workforce is preferable to specifically recruited workers. Secondly even though free condom distribution may seem attractive, the potential for its abuse (ie. workers collecting and reselling) it is real and therefore workers should be asked to pay normal cost when supplied cost. Anti-retroviral therapy even though desirable is obviously beyond the current per capita annual expenditure of most companies and may be a potential drain on Companies' medical expenditure.

The medical facilities need to determine and stock the "essential drugs" for HIV-related illnesses and this should be spelt out clearly. There are few relatively inexpensive drugs which can help ward off severe illness and add a few more months to a person living with AIDS'.

The example of the expenditure currently being made on one patient who is an anti-retroviral therapy is a clear signal to what companies will face if these decisions are not made upfront.

Since many employees tune in to the many radio stations in the country, as a corporate responsibility as a means for providing and varying the way HIV prevention messages are provided the cost of specific radio programmes aimed at workers should be factored into HIV prevention programmes.

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

While all the management staff of the companies and organizations studied are concerned about the growing AIDS situation in the country, only one has developed and started a comprehensive workplace programme on HIV/AIDS. In a couple of weeks another company will embark on another comprehensive programme .

The relatively low incidence of HIV/AIDS at the workplace means that there is little demonstrable economic impact on companies.

Currently financial costs to HIV/AIDS appear relatively low, but will increase significantly with the rise in HIV/AIDS cases in these organizations. Already, on the average, it costs one of the Companies \$5 - \$54.3 per episode of illness for the employees who are sick. The average expenditure for medical problems is estimated at \$10 per employee per year.

The current demand for STD management and prevention from employees is low in all the three organizations studied. This is a cause for concern because STD management and prevention is one of the main pillars for HIV prevention.

Given the availability of generous sickness packages that companies have compared to what pertains in the public sector and the availability of anti-retroviral drugs on the market, Management may have to come out with guidelines on the essential medical packages that will be provided.

6.2 Recommendations

1. Given the high levels of self-treatment of STDs any workplace programme should include STD management and the workers should be encouraged to use the facilities provided. Demand creation for STD prevention should be pursued.
2. Rapid ethnographic studies should be conducted to understand the workers' perceptions about STDs and STD services, as well as providers' attitudes towards clients.
3. The STD programmes should institute partner referral in order to detect and treat asymptomatic STDs particularly in women.
4. Businesses should identify and collect data required to help them predict changes in labour force demand and supply related to HIV/AIDS. Such data when collected should be analyzed in a timely fashion.
5. In localities of importance to Companies where the risk of infection is high, companies should extend the education and prevention programme to cover communities close to their facilities. The benefits to the business of this social investment initiative is less immediate but should be seen as actions designed to not only help reduce the risk to employees but also promote a healthy community.
6. The costs of the disease to the company must also be monitored and necessary action taken. In order to do the above an information system that enables companies monitor the health care costs, costs due to HIV/AIDS absenteeism and other related costs needs to be put in place.
7. Companies that have already started workplace programmes should share their experience with other businesses. There is already evidence that this is happening in some companies and so needs to be fostered.
8. There is the need for the National Workplace HIV/AIDS Policy being developed by the Ministry of Manpower Development and Employment to be finalized and approved. This would enable businesses take a cue and develop their specific Workplace Policies. In this regard the draft National HIV/AIDS and STI Policy should be finalised

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